UNIVERSITY PEDIATRIC UROLOGY, PC
2100 W. CLINCH AVE., STE. 120
KNOXVILLE, TN 37916
865-637-7290

PERMISSION FOR MEDICAL TREATMENT

Child's Name: ______________________________ DOB: ______________

The following people are authorized to seek medical treatment for my child in my absence:

________________________________ ______________
Name Relationship

________________________________ ______________
Name Relationship

________________________________ ______________
Name Relationship

________________________________ ______________
Name Relationship

Below are the numbers you may call me for any other medical information:

______________________ ______________________
Work Cell

______________________ ______________________
Guardian Name (print) Guardian Signature

*****Children under 18 years of age will NOT be seen without a guardian or person authorized by guardian.****